NON-PUBLIC?: N
ACCESSION #: 8802090610
LICENSEE EVENT REPORT (LER)

FACILITY NAME: D. C. Cook Nuclear Plant, Unit One PAGE: 1 of 4

DOCKET NUMBER: 05000315

TITLE: Engineered Safety Features Actuation (Reactor Trip) Due to the Inadvertant Opening of a Reactor Trip Breaker as a Result of Personnel Error
EVENT DATE: 01/13/88 LER #: 88-001-00 REPORT DATE: 02/04/88

OPERATING MODE: 1 POWER LEVEL: 090

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR SECTION
50.73(a)(2)(iv)

LICENSEE CONTACT FOR THIS LER:
NAME: K. R. Baker, Operations Department Superintendent
TELEPHONE #: 616-465-5901

SUPPLEMENTAL REPORT EXPECTED: No

ABSTRACT: On January 13, 1988, at 0821 hours, Unit One experienced an Engineered Safety Features Actuation (Reactor Trip) as a result of the inadvertant opening of the Train B Reactor Trip Breaker. At the time of this event the Unit was operating in Mode 1 (Power Operation) at 90 percent rated thermal power.

This event was the result of cognitive personnel error on the part of the licensed operator involved, who attempted to manipulate the Train B Reactor Trip Breaker instead of Reactor Trip Bypass Breaker B during the monthly Solid State Protection System (SSPS) surveillance.

Following the reactor trip all actions and verifications required by the facility emergency operating procedures were complied with and the Unit was stabilized in Mode 3 (Hot Standby).

Administrative controls have been established to ensure proper equipment configurations and adequate job briefings during surveillance testing. Procedural enhancements will be made to improve communications and component status verifications, and are tentatively scheduled for completion by April 7, 1988. Lastly, appropriate administrative action and counseling has been effected with the personnel involved in this occurrence.

(End of Abstract)

Conditions Prior to Occurrence

Unit One was operating at 90 percent reactor thermal power at the time of the event.

Description of Event

On January 13, 1988, at 0821 hours, Unit One experienced an Engineered Safety Features Actuation (Reactor Trip) from 90 percent rated thermal power. The actuation occurred as a result of a licensed operator inadvertantly manipulating a reactor trip breaker (EIIS-JE-BKR) instead of a reactor trip bypass breaker during the monthly Solid State Protection System (SSPS) (EIIS-JG) surveillance on Train B. The operator's intended function during this surveillance was to rack in Reactor Trip Bypass Breaker B.

During performance of the SSPS surveillance the licensed operator erroneously opened the cubicle door (EIIS-JE-CAB) for Reactor Trip Breaker B. Once inside, the operator experienced difficulty in manipulating (racking in) the breaker. When analyzing the situation the operator concluded that perhaps the breaker latching mechanism (EIIS-JE-MECH) was impeding breaker movement. By depressing the latching mechanism to facilitate breaker movement, the mechanical interlock (EIIS-JE-IMEC) with its associated shunt trip (EIIS-JE-17) was actuated thereby tripping the breaker and the Unit One reactor.

Following the trip sequence (opening of the reactor trip breakers (EIIS-JE-BKR), turbine (EIIS-TA-TRB) trip, insertion of the reactor control rods (EIIS-AA-ROD), feedwater isolation (EIIS-JB), automatic starting of the motor-driven and turbine-driven auxiliary feedwater pumps (EIIS-BA-P)) Operations personnel immediately implemented the Emergency Operating Procedure 1-OHP 4023.E-0 to verify proper response of the automatic protection system (EIIS-JC) and to assess plant conditions for initiating appropriate recovery actions. There was no automatic or manual actuation of the safety injection system (EIIS-BQ).

The Unit was stabilized in Mode 3 (Hot Standby) at approximately 0835 hours on January 13, 1988. The Nuclear Regulatory Commission was notified of the event via the Emergency Notification System at 0921 hours.

There were no inoperative structures, components, or systems that

contributed significantly to this event.

Cause of Event

Cognitive personnel error due to a failure of the licensed operator to properly identify/verify the correct breaker was the cause of this event. Investigation of this event determined that the breaker cubicles were properly labelled. However, the operator utilized the train designation instead of the breaker functional labelling to identify/locate the breaker. Contributing to this event were inadequate job briefing and failure to implement standard precautionary measures normally associated with this critical work.

Analysis of Event

This event is being reported in accordance with 10 CFR 50.73(a)(2)(iv) as an event that resulted in an unplanned automatic actuation of an Engineered Safety Feature including the Reactor Protection System.

The automatic protection system responses, including reactor trip and its associated actuations, were verified to have functioned properly as a result of the engineered safety features actuation. Based on the above, it is concluded that the event did not consitute an unreviewed safety question as defined in 10 CFR 50.59(a)(2) nor did it adversely impact the health and safety of the public.

Corrective Actions

Immediate corrective action involved Operations personnel implementing plant procedures to verify proper response of the automatic protection system and to assess plant conditions for initiation of appropriate recovery actions.

Action taken or to be taken to prevent recurrence:

1) Appropriate administrative action and counseling have been affected with the personnel involved in this occurrence.

2) The SSPS surveillance procedure involved in this event will be revised to improve interaction between operator and the technician. Areas to be improved include communications and status verification. The tentative completion date for this revision is April 7, 1988.

3) Administrative controls have been established to ensure proper equipment configurations and adequate job briefings during surveillance testing.

Failed Component Identification

None

Previous Similar Events

There have been no previous events involving the inadvertant manipulation of the reactor trip breakers during the monthly Solid State Protection System surveillance.

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February 4, 1988

United States Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Operating License DPR-58
Docket No. 50-315

Document Control Manager:

In accordance with the criteria established by 10 CFR 50.73 entitled Licensee Event Reporting System, the following report is being submitted:

88-001-00

Sincerely,
/s/ W. G. Smith, Jr.
W. G. Smith, Jr.

Plant Manager

WGS:afh
Attachment

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